An evidence-based model for understanding the mental health experiences of transgender Australians

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Abstract

A growing body of empirical research has documented the mental health experiences of Australian transgender people. This research indicates three key factors that appear to play a role in determining outcomes for adult transgender Australians: 1) discrimination, 2) access to hormones and/or surgery, 3) community connectedness. Two theoretical frameworks clarify why these factors exist and how they can lead to either negative or positive mental health outcomes. The first is cisgenderism, which describes the ideology that delegitimizes people's own understanding of their genders and bodies. Although anyone can experience cisgenderism, it is a particularly common experience for transgender people. The second is decompensation, which describes the processes through which the cumulative effects of stressors may lead to poor mental health. Drawing on both previous empirical findings and these two theoretical frameworks, this paper proposes, and provides initial testing of, a model for understanding the mental health of transgender adults in Australia. The paper concludes by suggesting the need for changes regarding how decisions are made about mental health service provision for transgender people, how mental health professionals understand the lives of transgender people, and how legislation can better ensure the full inclusion of transgender people in Australia.

Keywords: transgender, Australia, mental health, cisgenderism, decompensation, evidence-based model

Introduction

Over the past decade, an increasing number of studies have identified and reported on the mental health experiences of adult transgender Australians. Such research is important for three key reasons: a) it acknowledges the specificity of transgender people's mental health experiences and needs, b) it adopts a non-pathologizing approach that situates mental health outcomes for transgender people in a broader social context, and c) it identifies a range of likely determinants of transgender people's mental health. This identification of interactional rather than solely intrapsychic determinants has been an important first step in this expanding research field. The next step requires the development of models that can account for the interacting effects of multiple determinants. The development of such models is important not simply to enable their empirical testing, but also to facilitate the identification of gaps in practice, policy, and legislation regarding adult transgender people's mental health needs.

In order to develop a model of the determinants of transgender adults' mental health, the present paper begins by summarizing Australian literature on the topic. The paper then introduces two evidence-based theoretical concepts – cisgenderism and decompensation – that offer considerable explanatory power in accounting for the extant empirical research findings. These concepts are then applied to the development of a model that attempts to predict in a holistic fashion the determinants of mental health for Australian transgender adults. The model is then applied to data collected by the first author to provide an initial scoping of the utility of the model. The Australian focus is intentional:

Whilst Australian research findings to a large degree mirror those found in overseas studies, specificities arising from the Australian context indicate the merits of an Australian-specific model of adult transgender mental health. These specificities are discussed in the conclusion of the paper, which provides recommendations for changes to the training, policies, and practices of Australian mental health professionals, the services available to transgender adults in Australia (and the terms on which they are offered), and the Australian legislative contexts in which such services are provided.

Previous Research

To date, few Australian studies have addressed the mental health experiences of Australian transgender adults. As summarized below, this literature documents a relatively consistent image of the needs and experiences of transgender adults that both aligns closely with international research findings on the topic (e.g., Grant, Mottet & Tanis, 2011; McNeil, Bailey, Ellis Morton & Regan, 2012; Rotondi et al., 2011), whilst also demonstrating the specific ways in which current legislative and clinical contexts shape transgender people's mental health in Australia.

The first Australian empirical study that adopted an inclusive and non-pathologizing approach to understanding transgender people's mental health was documented in the *TranZnation Report* and subsequent publications by the team of researchers (Couch et al., 2007; Couch, Pitts, Croy, Mulcare & Mitchell, 2008; Pitts, Couch, Croy, Mitchell & Mulcare, 2009; Pitts, Couch, Croy, Mulcare & Mitchell, 2009). The TranZnation study

sample comprised 253 transgender people, of whom 229 were living in Australia (the remaining participants were living in Aotearoa/New Zealand at the time of the survey). With regard to the terminology utilized in the study, the majority of the sample (75.5%) reported that their sex was assigned male at birth, and this cohort was older than participants who were assigned female (the mean age of all participants was 41.1 years).

In the TranZnation study, self-reported mental health was assessed via the Prime-MD (Arnau, Meagher, Norris & Bramson, 2001), a 9-item screening questionnaire for depressive symptoms. The first two items in the questionnaire are evaluative. Just over half of the participants (53.4%) responded affirmatively to one or both of these items. An affirmative response to at least five of the nine items was used to indicate the presence of a 'major depressive disorder'. In this study, just over a third of participants (36.2%) met these criteria. Notably, the research suggests that meeting these criteria was significantly more likely for participants who were assigned male at birth (40.9%) than it was for participants assigned female at birth (21.3%), even when controlling for age differences between the two cohorts. However, older participants who were assigned male at birth reported fewer depressive symptoms than did younger participants assigned male at birth. Overall, the number of participants who met the researchers' criteria for 'major depressive disorder' was considerably higher than that found in previous Australian general population research. Goldney, Fisher, Wilson and Cheok (2000), for example, found that only 6.8% of participants in a community sample of 3010 South Australians met criteria for depression according to the Prime-MD.

One clear explanatory factor for the lower levels of mental health identified in the TranZnation survey was the experience of transgender-related discrimination. Participants were asked to indicate the number of different types of discrimination they had experienced (from a total of 18 different types listed in the survey). Participants who had experienced more types of discrimination were more likely to meet the Prime-MD criteria for 'major depressive disorder': "10 percent of those who had not experienced any of the listed types of discrimination were depressed, while just over 60 percent of those who had experienced 10–12 types of discrimination were currently depressed" (Couch et al., 2007, p. 65).

The second survey documenting the mental health experiences of transgender Australians was reported in *Private Lives 2* (Leonard et al., 2012). The survey that informed the report focused on the health and wellbeing of gay, lesbian, bisexual and transgender Australians. Of the 3835 respondents, 4.4% reported identifying as transgender (N = 169). Very similar to the *TranZnation Report* (Couch et al., 2007), the majority of transgender participants in the *Private Lives 2* report selected the available category 'transgender female' (72.18%), with the remainder selecting the category 'transgender male'. The mean age of the overall sample of 3835 participants was 37.7, though no subsample mean is provided for transgender participants.

Self-reported mental health was assessed via the K10 (Kessler et al., 2002), a 10-item measure of psychological distress. Each item offers a 5-point Likert response, with overall higher scores used to determine higher levels of psychological distress (the

maximum possible score is 50, and the minimum 10). Australian population data collected with 8841 adults indicates that the average response to the K10 nationally is a score of 14.5 (Slade, Grave & Burgess, 2011). The *Private Lives 2* data indicate mean scores of 23.22 for transgender male participants and 23.20 for transgender female participants.

Boza and Nicholson Perry (2014) conducted a third survey with a sample of 255 respondents, of whom the research reports 168 as being assigned male at birth and 87 as being assigned female at birth. The mean sample age was 38.15. Self-reported mental health was assessed via the Center for Epidemiological Studies Depression Scale (CES-D, Radloff, 1977). Similar to the K10, the CES-D uses a Likert scale (4 points) and includes 20 items, with a CES-D score of 16 used as a clinical cut-off for depression. In this sample, 59.3% exceeded the cut-off for depressive symptoms. Depressive symptoms were lower amongst participants assigned female at birth than amongst participants assigned male at birth, and were also lower amongst participants who were currently taking hormones and/or who had gender-affirming surgeries.

The Boza and Nicholson Perry (2014) survey also asked participants to report instances of transgender-related victimization. Similar to the *TranZnation Report* (Couch et al., 2007), Boza and Nicholson Perry found a relation between victimization and depressive symptoms: The more a participant had experienced victimization, the higher their score on the CES-D. Participants who had lower social support also scored higher on the CES-D. In a stepwise regression model, social support explained the greatest amount of

variance (6.6%) in depressive symptoms.

del Pozo de Bolger, Jones, Dunstan and Lykins (in-press) report on a survey of 278 Australian people who were assigned female at birth and who did not identify as female at the time of the survey. In the quantitative data section, 69% of the sample reported having received a diagnosis of depression in the past year. Participants were asked to report what they felt contributed to their depression. The greatest number indicated that 'personal issues with gender identity' contributed to their depression, and to a lesser extent that 'experiences of discrimination' contributed to depression. The extent to which these two factors (i.e., dysphoria vs. discrimination) are separable is subject to debate. Further clarity regarding their separation is unavailable from these data. Participants who had undertaken gender-affirming surgeries reported that such surgeries contributed to improved mental health.

Finally, Riggs and colleagues (Riggs & Due, 2013a; b; Riggs, Coleman & Due, 2014; Treharne & Riggs, 2014) reported findings from a survey of 188 transgender Australians, of whom the research refers to 110 participants as being assigned male at birth and 78 as being assigned female at birth. The mean age of participants was 44.87, although participants assigned male at birth were on average older than were participants assigned female at birth, and were also more likely to have undertaken gender-affirming surgeries.

In terms of mental health, Riggs and colleagues asked participants to self-report their mental health on a single 5-point Likert scale, where 1 indicated poor mental health and 5

indicated very good mental health. Participants who had undertaken gender-affirming surgeries were more likely to report better mental health; however, when comparing those who didn't want surgery in the future with those who did, those who did not want surgery reported better mental health. Participants who were older reported better mental health. When controlling for age, the study found that participants assigned female at birth as a group reported better mental health than did participants assigned male at birth. The importance of other people's perception of their gender identity (again on a 5-point Likert scale) was negatively correlated with self-reported mental health, such that the more a participant was concerned with the evaluations of others, the poorer their mental health. The research also found that a greater sense of connectedness to the community at large (measured by the 10-point Sense of Community Scale: Chavis, Lee & Acosta, 2008) was positively correlated with mental health.

Collectively, these five studies indicate a relatively consistent picture of transgender adults' mental health in Australia. Specifically, they indicate that:

1. Levels of poor mental health appear to be higher amongst transgender people than among Australians overall,
2. There is a relation between experiences of discrimination and poor mental health,
3. Age appears to play an important role in determining mental health outcomes,
4. Social support and community connectedness may mitigate the impact of discrimination on transgender people, and
5. There is a positive relation between taking hormones and/or undertaking gender-

affirming surgeries and mental health for those who desire these interventions.

In order to develop a model from these findings that can increase understanding and predict mental health outcomes for transgender people, it is important to first introduce two key theoretical concepts that elucidate the broader contexts through which transgender people's experiences are shaped.

Theoretical Frameworks

Cisgenderism

The term *cisgenderism* comes from the Latin prefix *cis-*, meaning 'on the same side', and *gender* from the Latin *genus*, meaning 'kind' or 'type'. The term *cisgenderism* was initially used interchangeably with the term *cisgender* to describe people who are 'not transgender'. More recently, however, the term cisgenderism has been used to describe the ideology that delegitimizes people's own understanding of their genders and bodies (Ansara & Hegarty, 2012). Cisgenderism is particularly common where people's understandings differ from those assumed based on their assigned sex category. Forms of cisgenderism explored in previous research include:

1. Pathologizing, which refers to constructing or treating people's genders, bodies, and experiences associated with their genders and bodies as disordered. Pathologizing is apparent in terminology that groups people's lives using

negative classifications (e.g., ‘gender identity disorder’, ‘gender dysphoria’, and ‘disorders of sex development’)

2. Misgendering, which refers to the misclassification of people’s genders and bodies. Examples of misgendering include not using someone’s current name, describing a woman who was assigned as male as ‘a man’, or describing someone who identifies as male as ‘a biological female’.

As a theoretical framework reflective of actual practices, cisgenderism describes systemic and individual acts that occur in various cultural contexts. These acts can be both hostile and benevolent, and both intentional and unintentional. As outlined extensively by Ansara and colleagues (Ansara, 2012; Ansara & Hegarty, 2012; 2013; 2014; Blumer, Ansara, & Watson, 2013), cisgenderism as a theoretical framework can be applied to investigate distinct manifestations of delegitimizing ideology regarding bodies and identities across diverse cultural contexts.

The cisgenderism framework is informed by two social science approaches: Critical disability studies and ethnocentrism studies. The cisgenderism framework shares with critical disability studies a critique of the external application of labels that are experienced as stigmatizing and/or inaccurate by the people to whom they are applied. The cisgenderism framework also emphasizes the critique articulated within ethnocentrism studies of the presumption that categories developed in one particular cultural context can be applied outside of that context. For example, colonial US and European notions of ‘trans’ are based on culturally relative assumptions that there are

only two valid genders, that gender is determined by external genital appearance at birth, and that 'trans' people go from one of two valid options to the other. This approach gives rise to forms of cisgenderism such as *coercive queering* (in which self-identified heterosexual people who have 'trans' life experiences or an intersex body are conflated with lesbian, gay, bisexual, or queer individuals) and *retroactive misgendering* (in which a person's past is described without their consent using language that invalidates their current gender self-identification). We note that the aforementioned Australian research often relied on de-gendering biological language that did not clarify participants' own gender identities. In addition to de-gendering, misgendering is more likely to occur when people's own descriptions of their genders and bodies are constrained by research design (see Treharne, 2011; Ansara, 2012).

Cisgenderism as a theoretical framework has much to offer towards understanding the mental health experiences of transgender Australians (though it has much wider application beyond this population). Specifically, it allows for an understanding of the broad range of everyday and institutional practices that may adversely impact transgender people. The theoretical framework of cisgenderism is not reliant on an account of the beliefs or values of any given group. Rather, it emphasizes the normative presumptions that shape countries such as Australia, such as the presumptions that gender follows from assigned sex category and that sex assignation (utilizing a two-sex model) is a useful way of differentiating between bodies. Many issues arising from cisgenderism are likely to be daily stressors for transgender Australians. Coping with stressors arising from being considered outside social norms can be modelled using two concepts: compensation and

decompensation.

Decompensation

Within medical literature, the term 'decompensation' refers to when a bodily organ ceases being able to compensate for stressors or defects (Joseph, Cedars, Ewald, Geltman & Mann, 2009). In psychiatry, the term has been used to describe the point at which psychological defenses against stressors cease to function (Smith, 1998). In the present paper, we utilize the term to describe the vulnerabilities that may arise when a transgender person is no longer able to psychologically compensate for the accumulative effects of cisgenderism. To compensate in this context, then, is similar to the notion of coping, although engaging in compensatory behavior does not necessarily mean the individual feels they are coping well. Within Lazarus and Folkman's (1984) transactional model of stress and coping, compensatory behavior is aligned with the individual's secondary appraisal of their coping methods, and appraisals of coping efficacy proceed in hand with primary appraisal of the stressors they encounter. For diverse reasons, some transgender people may cease being able to engage in such compensatory behaviors. This cessation is what we refer to as decompensation; An understandable scenario that arises from the injustice of exclusionary social norms.

We stress that decompensation is not a 'failure' of compensation by transgender people – it is not representative of any pathology inherent to transgender people. Rather, decompensation occurs as a result of the cumulative negative effects of the stressors

themselves. This distinction between post-traumatic responses and intrapsychic pathology has been made in previous trauma research (see Brown & Pantalone, 2011). Thus decompensation as a theoretical framework draws attention to pathologies inherent to societies in which one particular model of being is imposed on all people. The systemic discrimination for which a transgender person may be forced to compensate can manifest as an ongoing series of interactions, events, and daily hassles collectively termed 'microaggressions' (Nadal, Skolnik & Wong, 2012). There may come a point, we contend, when individuals who can no longer compensate are not only exposed to the full impact of trauma due to social norm stressors, but also rendered susceptible to further generalized stressors as a result of their compromised defenses. A key point when applying decompensation to transgender people is that most transgender people are frequently required to compensate in the first place – this is an unreasonable expectation of any population, particularly (and uniquely) when experienced by transgender people impacted by cisgenderism.

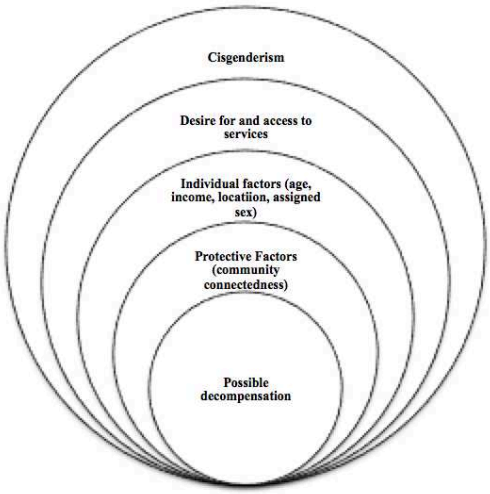
The applicability of decompensation to transgender people's mental health is clearly demonstrated in two pieces of research. The first, undertake by Toomey, Ryan, Diaz, Card and Russell (2010), found that in their sample of 245 young "gender non-conforming" people living in California, all of the variance in life satisfaction and depression was explained by the degree of perceived discrimination they had faced due to their perceived gender non-conformity. Similarly, in their study of 192 transgender women living in Ontario, Rotondi and colleagues (2011) reported that "higher levels of transphobia were associated with higher odds of depressive symptomatology. Each

increase of one point on the transphobia scale corresponded with a 13% increase in the odds of depression" (p. 126). As a theoretical framework, then, decompensation supplements the cisgenderism framework by accounting for why cisgenderism leads to poor mental health outcomes for transgender people. This integrated model also explains the decompensatory effects of cisgenderism in a way that moves beyond the mischaracterization of depression as a psychological property common to transgender people, and toward an evidence-based understanding of the interactional and systemic aetiology of elevated depressive symptomatology among transgender populations.

Model

Figure 1 outlines the proposed model of transgender mental health in Australia, drawing on the research summarized above and incorporating the theoretical frameworks of cisgenderism and decompensation.

Figure 1. Model of transgender mental health in Australia



As displayed in the model, factors influencing transgender adults' mental health are shaped by the broader context of cisgenderism. Cisgenderism influences:

1. Whether or not an individual desires hormones and/or surgery, and health professionals' responses to these desires.
2. In distinct ways, the experiences of individuals according to their social location (e.g., younger people may experience reduced access to services and/or older people may experience greater social isolation. Transgender people living in remote areas and/or who are on reduced incomes and/or who are members of a marginalized cultural or ethnicized group may experience both),
3. Responses from the communities and systems with which they interact (including friends, family, partners, employers, institutions, and strangers).

When the effects of cisgenderism exceed any individual's capacity to manage or cope, then the model suggests that decompensation may occur. This decompensation may present as a specific mental health concern (e.g., depression, anxiety, agoraphobia), as a more generalized sense of helplessness and inability to function, or as a loss of belief that change is possible and that transgender-related goals are attainable (e.g., social acceptance, hormones, surgery, safe housing, education, or employment, and/or an intimate relationship in which someone's own understanding of their gender is respected). Importantly, the reverse can also occur: If a transgender person receives competent and inclusive care that acknowledges their autonomy and their own understanding of their gender and body, and if they experience support and acceptance

from their local communities and close social networks, then they will be more likely to achieve their self-determined goals and thus be more likely to have better mental health outcomes.

Importantly, the model does not discount mental health concerns that may exist for some transgender people *outside* of those arising due to cisgenderism. Transgender people, like all Australians, may experience poor mental health as a result of various factors unrelated to transgender experience. The model accepts the possibility of mental health concerns on par with the overall Australian population, as per the aforementioned Australian data.

Application of the Model

In order to test the above model, it is now partially applied to data collected by the first author. Data collected by Riggs and colleagues (Riggs & Due, 2013a; b; Riggs, Coleman & Due, 2014; Treharne & Riggs, 2014) were subjected to a secondary analysis, facilitated by recoding the continuous variable of age into a categorical variable with two categories: Participants aged 25 and under, and participants aged 26 and over (full details of the method are provided in Riggs & Due, 2013). This division aligns with the current Australian use of age 25 to demarcate between 'young adults' and 'adults'.

In terms of the effects of cisgenderism, the survey included a 5-point item asking participants about the degree to which they were concerned with other people's perceptions of their gender identity. The recoded data showed that those in the younger

age category were more concerned with other people's perceptions ($M = 4.27$, $SD = 1.04$) than were those in the older age category ($M = 2.85$, $SD = 1.24$), $t = 3.976$, $p < 0.5$. It is possible that differential access to surgery (as outlined below) rendered participants in the younger age category more susceptible to the effects of cisgenderism, and specifically misgendering due to other people's perceptions. This suggestion was corroborated by the negative relation between concern with other people's perceptions and mental health, $r = -.372$, $p < .05$. If young participants were more concerned with other people's perceptions, then this potentially rendered them more vulnerable to decompensation as compared to older participants.

Further, in terms of the effects of cisgenderism, participants in the younger age category were less likely to have had gender-affirming surgery, $\chi^2 = 15.934$, $p < .05$, and were more likely to desire gender-affirming surgery $\chi^2 = 12.763$, $p < .05$. Whilst the reasons for differential access to surgery between the younger and older age categories are not entirely unclear, this finding may in part have been a product of responses from mental health professionals. Again using a 5-point scale, participants in the younger age category reported lower levels of satisfaction with psychologists ($M = 2.30$, $SD = 1.21$) than did participants in the older age category ($M = 3.49$, $SD = 1.09$), $t = 3.424$, $p < .01$. Similarly, participants in the younger age category reported lower levels of satisfaction with psychiatrists ($M = 2.52$, $SD = 1.22$) than did participants in the older age category ($M = 3.47$, $SD = 1.06$), $t = 3.311$, $p < .001$. These findings may indicate the effects of cisgenderism on decision-making amongst mental health professionals and the resultant types of support and responses provided to younger transgender adults as compared to

older transgender adults.

It would appear, then, that the impact of cisgenderism (in the forms measured by the survey) varies according to age (and its possible relation to accessing surgery). The impact of this individual factor of age was confirmed by the finding that people in the younger age category reported poorer mental health ($M = 2.81$, $SD = 1.20$) than did people in the older age category ($M = 3.78$, $SD = 0.99$), $t = 4.930$, $p < 0.1$.

In terms of potential protective factors, the findings suggest that participants who had gender-affirming surgery felt more connected to the general community ($M = 30.73$, $SD = 9.74$) than did participants who had not had surgery ($M = 26.60$, $SD = 8.34$), $t = 2.682$, $p < .01$. Given, as outlined above, participants in the younger age category were less likely to have accessed surgery, this cohort may have benefited less from the potential buffer that a sense of general community connectedness can provide against cisgenderism. This is notable given that correlations indicated both a positive correlation between sense of connectedness to the community at large and mental health, $r = .320$, $p < .001$, and a positive correlation between age and sense of connectedness to the community at large, $r = .259$, $p < .01$. This suggests that younger participants felt less connected to the community at large, thus benefitting less from the potential buffer such a sense of connectedness can provide against decompensation.

Conclusions

It is important to first note that some of the potential protective factors identified from these data are arguably a part of the very cisgenderism they notionally combat. In other words, experiencing an injunction to physically inhabit one of two prescribed and normatively accepted bodies is potentially a product of cisgenderism itself. For example, existing medical systems typically restrict the autonomy of transgender people who desire some but not other available medical interventions (e.g., male chest reconstruction surgery and metaoidioplasty without testosterone; phalloplasty without vaginectomy; vaginoplasty without facial hair removal; etc.) or who seek gender-affirming medical interventions in a viable sequence that differs from standard medical policy (e.g., male chest reconstruction surgery prior to testosterone; orchidectomy prior to oestrogen; etc.). In addition, the choice between a metaoidioplasty and a phalloplasty, and decisions about whether to have scrotal or breast implants and facial feminization surgery may be constrained by available government and private health insurance coverage. Thus the medical preferences and decisions of transgender people are shaped and constrained by systemic forms of cisgenderism. The fact that not all participants desired surgery (and that not desiring surgery was statistically associated with better mental health) indicates that, whilst the ability to access surgery (if desired) is an important determining factor in decompensation for some transgender people, it is not necessarily the only option.

Despite this proviso, both the model and its application to these data indicate that access to surgery is vital for many transgender people in Australia. Of note is the fact that, at present, surgery in Australia is only possible with a formal diagnosis of ‘gender dysphoria’. For those people who desire one of various gender-affirming surgical

procedures, but who for a range of reasons cannot or will not meet the diagnostic criteria, the negative mental health implications are substantial. For other people, whilst a diagnosis may be possible and often given, this does not necessarily mitigate the pathologizing and stigmatizing effects of diagnosis itself. It is argued within the DSM-5 (American Psychiatric Association, 2013) that the 'gender dysphoria' diagnosis (replacing the DSM IV-TR diagnosis of 'gender identity disorder') is less stigmatizing and only applicable if a person experiences dysphoria. However, the requirement of diagnosis before accessing hormones or surgery indicates its enduring regulatory function. In addition, the practice of withholding gender-affirming medical intervention prior to a transgender person experiencing the severe distress required for a 'gender dysphoria' diagnosis – a restriction which may result in some transgender people experiencing an unnecessary degree of distress before their needs are met – is contraindicated by evidence that suggests this distress and associated decompensation may be prevented by early intervention to provide transgender people with their desired access to hormones and/or surgery (e.g., Colizzi, Costa, Pace, & Todarello, 2013; Kreukels & Cohen-Kettenis, 2011).

Of course, some form of regulation is needed in order to monitor access to hormones and surgery: Medical professionals have a duty of care to ensure they do no harm. Yet the analogy of prophylactic mastectomy serves to demonstrate that a diagnosis need not be required for a particular medical course of action, and that this early intervention to prevent future harm is standard practice in medical decision-making beyond gender affirmation. In the case of prophylactic mastectomy surgery to prevent possible future

breast cancer, screening is undertaken to identify if the BRCA1 gene is present, and genetic counseling is undertaken to determine if there is a family history of breast cancer (see Crabb & LeCouter, 2006). Despite this screening, clinicians can only estimate the likelihood of breast cancer, and not provide clear evidence that the individual will actually develop breast cancer. In other words, what is being 'treated' in the case of a prophylactic mastectomy is not a current disease, but a possible future disease – thus a formal diagnosis is not given. To compare this approach to clinical responses to transgender people, then, it is reasonable to suggest that a course of action in terms of hormones and/or surgery could be warranted to reduce the likelihood of future decompensation occurring, rather than waiting for decompensation (or what it is arguably termed – 'dysphoria') to occur.

Indeed, this harm reduction approach to supporting the prescription of hormones and/or surgery is clearly outlined in the World Professional Association for Transgender Health's *Standards of Care* (WPATH, 2011). The *Standards of Care* hold as central transgender people's right to autonomy, and their ability to authorize their treatment via informed consent. Whilst the Standards of Care utilize the language of 'dysphoria' as a criterion for the prescription of hormones and/or surgery, this is not delineated as a formal diagnosis. Rather, it is shorthand for a person's lived experience of their assigned sex at birth and the gender with which it is normatively associated differing from their own sense of their gender identity and their body. Closer adherence to these internationally recognized *Standards of Care* in Australia would thus be an important step away from a pathologizing and unnecessarily restrictive approach to transgender

people, and towards one where transgender people are supported in decision-making practices that validate their gender identity.

Whilst this paper has encouraged a shift away from formal diagnosis as an absolute requirement, it is vital not to discount some transgender people's self-reports of dysphoria. Whilst the present paper is critical of cisgenderist ideology and of cisgenderist policies and practices, it is not reasonable to expect transgender people to exist outside of cisgenderism: It is entirely reasonable that some transgender people will treat the injunction to conform to one of two prescribed bodies as legitimate. Our point here is not to discount the journey or experience of any transgender person. Rather, it is to suggest that where clinicians can identify both the existence of cisgenderism and the likely potential for decompensation, they should aim to offer options without the need for formal diagnosis. This need for options without formal diagnosis is particularly important given that many transgender people experience this requirement as a form of paternalistic gatekeeping, and one that some researchers suggest has produced particular circumscribed narratives about transgender embodiment, rather than encouraging open discussion about people's clinically relevant needs and concerns (Speer & McPhillips, 2013).

Shifts away from the requirement of formal diagnosis are evident in recent changes to Australian federal policy for changing gender markers on passports. Whilst such changes currently require a letter from a psychologist or medical practitioner stating that they have witnessed a person's declaration of their gender, the *Australian Government*

Guidelines on the Recognition of Sex and Gender do not require any particular diagnosis by the psychologist or medical practitioner (Commonwealth of Australia, 2013). This, however, is not the case for documents at the state or territory level. For example, a young person's name can be changed on their birth certificate with parental approval, yet their gender marker cannot be changed without a diagnosis and surgery approved by the Family Court of Australia, as in RE: Jamie (2013). Similarly, an adult transgender person who is in a mixed-gender marriage prior to transitioning cannot legally change their birth certificate unless they divorce their spouse (as 'same-sex' marriages are not legal in Australia). These examples suggest that further legislative changes are required to meet the needs of transgender people, and that such changes should bring state and territory legislation into line with federal legislation.

Moving beyond the effects of diagnostic requirements on transgender people in Australia, it is important to consider how such requirements impact Australian clinicians, including those clinicians who are transgender people. Given the authority accorded to diagnoses, it is reasonable to suggest that this authority may encourage an over-emphasis on diagnoses in therapeutic responses to transgender people. Put differently, the current lack of skills and sensitivity widely reported by transgender people who engage with clinicians in Australia (e.g. see Riggs, Coleman & Due, 2014) is likely to be a product of clinicians' inculcation into a diagnosis-centric approach, and may persist despite any particular clinician's non-cisgenderist attitudes towards transgender people. This structural factor is consistent with the cisgenderism framework, which emphasizes how the systemic

delegitimization of people's own understanding of their genders and bodies affects the actions of even those individual professionals who do not have cisgenderist attitudes.

Further testing of the proposed model is needed urgently. The application provided in the present paper is limited by available data (which did not adequately assess cisgenderism or decompensation), and which can only be taken as an initial indication of the potential utility of the proposed model. The present paper and the data to which the model is applied included an almost exclusively white sample, comprised primarily by people who self-identify as transgender or transsexual. This is likely to have excluded people who identified simply as women or men and who did not complete the survey due to not labelling themselves according to these gender history descriptors. In the present paper more broadly, it is important to acknowledge that despite the cisgenderism framework's critique of the 'cisgender'/'transgender' binary as essentialist (and the authors' awareness that this critique of essentialist classifications is a key component of this framework), we have used the language intelligible to Australian clinicians (i.e., 'transgender people') in order to initiate dialogue regarding some aspects of this framework.

It is also potentially the case that the proposed model may not be applicable to groups such as Indigenous sistergirls and brotherboys, nor to people who identify as genderqueer, neutrois, agender, bigender, or enby. Furthermore, whether or not the model is applicable to people under the age of 18 cannot be determined from the available data. Although the burgeoning body of research on transgender young people in Australia suggests that similar issues may pertain to this population (Riggs & Due, 2014; Riley,

Sitharthan, Clemson & Diamond, 2011; Robinson, Bansel, Densen, Ovenden & Davis, 2014), the applicability of the model can only be determined by additional research and consultation with these communities and with transgender individuals who are isolated from or unable to engage with these communities.

In conclusion, the commentary and research documented in this paper suggest the pressing need to test evidence-based models that seek to explain the mental health experiences of transgender Australians. These models should be holistic and flexible, rather than prescriptive or static. These models must be responsive to ongoing and often rapid changes in Australian society and its institutions. Furthermore, any model should be dynamic, offer clear guidance to clinicians, and provide practical directions for researchers. Our proposed model meets these requirements by being grounded in empirical research and theoretical frameworks, by offering a range of pathways and suggested adaptations to meet shifting needs, and by acknowledging that the aim of any approach should always be the best outcomes for transgender people *as they determine the best outcomes to be.* Understanding and acknowledging barriers that prevent optimal outcomes is an important step towards ensuring systemic changes that can meet the diverse needs of transgender people and communities in Australia.

Key points

What is already known about this topic

- Transgender people in Australia experience poorer mental health than the general population
- Transgender people's mental health is shaped by the effects of discrimination and exclusion
- Community connectedness and access to hormones and/or psychological support that validates and respects people's own understanding of their genders can mitigate the negative effects of discrimination and exclusion

What this topic adds

- The paper proposes an evidence-based model for understanding transgender mental health in Australia
- The paper provides initial testing of this model on available Australian data
- The paper makes recommendations for changes to practice and legislation to improve transgender people's mental health and wellbeing and to prevent decompensation

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